



Maryland Health Care Commission

Thursday, June 18, 2015

1:30 p.m.

1. **APPROVAL OF MINUTES**
2. UPDATE OF ACTIVITIES
3. ACTION: Certificate of Need: Lorien Harford Nursing and Rehabilitation Center
4. ACTION: Certificate of Need Exemption: Seasons Hospice/Optum Hospice Merger
5. PRESENTATION: Plans for Development of State Plan for Freestanding Medical Facilities
6. UPDATE: Results for the State EHR Incentive Program
7. UPDATE: Results of the Analysis of Payment for Professional Services
8. UPDATE: Evolution of the Small Group Market
9. Overview of Upcoming Initiatives
10. ADJOURNMENT

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AGENDA

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ACTION:

Certificate of Need: Lorien Harford Nursing and Rehabilitation Center

(Agenda Item #3)

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ACTION:

Certificate of Need Exemption: Seasons Hospice/Optum
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(Agenda Item #4)

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PRESENTATION:

Plans for Development of State Plan for Freestanding Medical
Facilities

(Agenda Item #5)



Regulatory Oversight of Freestanding Medical Facilities

Development of New State Health Plan Regulations

Center for Health Care Facilities Planning and Development

June 18, 2015



Overview

ing Emergency Centers (FECs)

- **The Maryland Version of the FEC – the Freestanding Medical Facility**
- **Development of the State Health Plan**
- **Basic Framework for FMF Development**
- **Draft Project Review Standards**
- **Next Steps**



Freestanding Emergency Centers

- Independent emergency centers or satellite hospital out-patient departments (ACEP)
- Filling gap on spectrum of emergency medical service between the hospital ER & the urgent care center or primary care physicians office setting
- A vehicle for improving access to emergency care in rural & underserved areas or urban areas with severe traffic congestion
- A vehicle for reducing overcrowding in the hospital ER



Freestanding Medical Facility (FMF)

- Operate as satellite hospital outpatient departments – but separately and distinctly licensed health care facilities
- Provide unscheduled outpatient services
- Open 24 hours per day / seven days a week
- Subject to EMTALA
- Required Services
- Required Staffing
- Required Equipment



The Maryland FMF Pilots

- **Germantown Emergency Center** - established by Adventist HealthCare's Shady Grove Medical Center in 2006
- **Queen Anne's Emergency Center** – established by the University of Maryland Medical System's Shore Medical Center at Easton in 2010
- **Bowie Health Center** – not a pilot but licensed as an FMF – formerly operated under license of its parent, Prince George's Hospital Center – operational since 1979
- MHCC has reported to the General Assembly on the operations, utilization, & financial performance of FMFs
- The “pilot” period ends in 2015



Inputs for State Health Plan (SHP) Development

- The statute
- Licensure regulations
- Mandated studies of the pilot projects
- Literature review
- Policies and standards developed by national bodies and other states



The Basic Framework for FMF Development

- FMFs should be established in parent hospital primary service areas
- Establishment of FMFs should respond to
 - Overcrowding of the parent hospital ER or parent hospital system's ERs that warrants expansion of hospital ER capacity *and/ or*
 - The need for improved access to emergency medical care in the parent hospital (system) service area



Project Review Criteria

- Need
- Access
- Cost and Effectiveness
- Feasibility/Viability
- Quality
- Impact



Project Review Standards

- Specific problem to be addressed by FMF development – overcrowded ER(s) and/or need for improved access
- Alternatives that have tried to address the problem(s)
- Target population
- Historic trend in use of hospital ER(s)
- Role of urgent care centers & other walk-in care options
- Insurance coverage of target population
- Space and capacity guidelines (ACEP)



Project Review Standards

- Optimize travel time access for service area population
- Consistency with State Health Improvement Plan for hospital EDs – reducing visits for chronic disease conditions
- Needs of underserved populations
- Improved care coordination



Project Review Standards

Cost and Effectiveness

- Evaluation of alternatives
- Focus on primary care and urgent care alternatives

Feasibility/Viability

- Quality of and basis for assumptions
- Community support
- Availability of workforce
- Use of process improvement/health information technology



Project Review Standards

Quality

- Use of established quality measures
- Outcome and performance measurement
- QA programming

Impact

- Parent hospital and parent system
- Other hospitals
- Cost of emergency care



Next Steps

• for informal review and comment

- **FMF Work Group**

- Assist staff in development of proposed regulation

- Adoption of proposed new SHP chapter (Fall 2015)
- Adoption of final regulations (by end of year)
- Schedule opportunities for application review (early 2016)

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UPDATE:

Results for the State EHR Incentive Program

(Agenda Item #6)

State-Regulated Payor Electronic Health Records Incentive Program:

Summary of Program Progress

June 18, 2015



The MARYLAND
HEALTH CARE COMMISSION

State Incentive Program Background

- **Maryland law enacted in 2009 requires MHCC to establish electronic health record (EHR) adoption incentives from certain State-regulated payors**
 - **Law aims to promote EHR adoption and use among practices in Maryland, given the relatively low EHR diffusion in 2009**
 - **In 2009, EHR adoption among Maryland office-based physicians was 19 percent, compared to a national rate of 22 percent**
 - **MHCC convened the State-Regulated Payor EHR Adoption Incentive Program (State incentive program) Workgroup to develop recommendations, which framed the regulation**
 - **The regulation went into effect on April 21, 2011 and was amended on October 21, 2011**

State Incentive Program - Key Provisions

- Eligibility – Primary care practices, including family, general, internal medicine, pediatrics, geriatrics, and gynecology
- Must adopt a certified EHR in order to qualify
- The six largest private payors required to provide incentives include: Aetna, CareFirst, Cigna, Coventry, Kaiser Permanente, and United Healthcare
- One time payment per payor per practice
- Incentive of up to \$15,000 – based on the practice's panel members, calculated at \$25 per member

Federal Incentive Programs Background

- The American Recovery and Reinvestment Act of 2009 authorizes the Centers for Medicare & Medicaid Services (CMS) to provide incentive payments to eligible professionals (EPs) and hospitals
- CMS Medicare and Medicaid EHR Incentive programs (federal incentive programs) began January 2011
- Must adopt, implement, upgrade, or demonstrate meaningful use (MU) of certified EHR technology to receive an incentive
 - Maximum Medicare incentive of \$44,000 over five years through 2016
 - Maximum Medicaid incentive of \$63,750 over six years through 2021
- MU requirements were developed to become more advanced as EPs and hospitals progress through three stages

Federal Incentive Programs Eligibility

Medicare	Medicaid	
Doctors of medicine or osteopathy	Doctors of medicine or osteopathy	30% minimum Medicaid patient volume *20% for Pediatricians Or EP practices predominately in FQHC or RHC with 30% needy individual patient volume
Doctors of podiatric medicine	Nurse practitioners	
Doctors of optometry	Certified nurse-midwives	
Chiropractors	Dentists	
Doctors of dental surgery or dental medicine	Physicians assistants working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is so led by a physicians assistant	
Hospital-based EPs are NOT eligible for incentives 90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital		

2013 State Incentive Program Assessment
&
*Alignment with the
Federal Incentive Programs*

2013 State Incentive Program Assessment

- Staff assessed the progress of State incentive program to ensure its continued progress in meeting the intent of the law
- Findings:
 - State incentive program was largely aimed at paying for the purchase of software (rebates)
 - Misalignment with the federal incentive programs created operational challenges for primary care practices
 - State incentive program participation trailed significantly when compared to the federal incentive programs
 - About four percent of eligible primary care physician practices had received a State incentive, while 29 percent had received a federal incentive

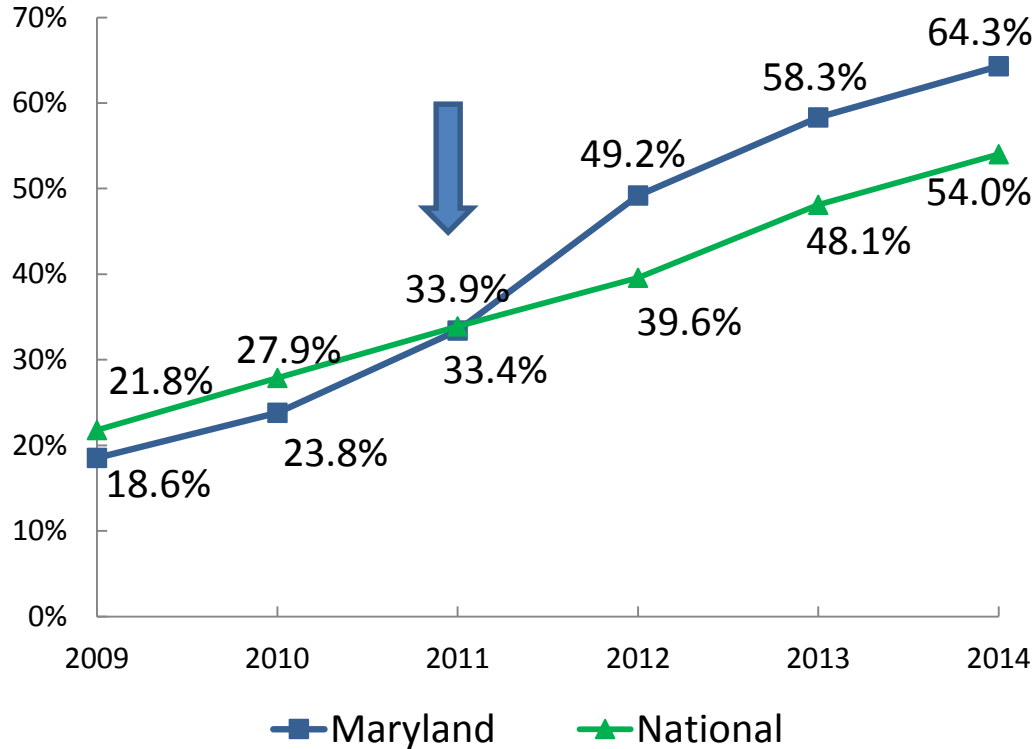
Key State Incentive Program Changes

- Amended regulation effective June 9, 2014; program changes effective October 7, 2014
 - Qualification for an EHR incentive payment: (1) one or more physicians within the practice have attested to MU; or (2) a primary care physician practice participates in an MHCC approved PCMH program and achieves NCQA PCMH recognition
 - Streamline the administration of the State incentive program application and payment process
 - Clarify the definition of a primary care practice eligible for an incentive payment
 - Extend the sunset date by two years to December 31, 2016

Expanded Outreach Activities

- In an effort to raise awareness regarding availability of the State incentive program and new provisions, the below were targeted:
 - Primary care providers that had either registered or attested to MU under the federal incentive programs
 - Individuals who contacted the MU help desk
 - Management service organizations who work with providers to achieve MU
- Outreach methods included, fax blasts, e-mails, newsletters, and website posts
- Efforts implemented in collaboration with The Maryland State Medical Society, MedChi; the Department of Health and Mental Hygiene (DHMH); the Chesapeake Regional Information System for our Patients (CRISP); and the Maryland Nurses Association

EHR Adoption Among Office-based Physicians



EHR adoption among Maryland office-based physician has increased from 33.4 percent in 2011 (around the time the State incentive program went into effect) to 64.3 percent in 2014

Sources:

- Maryland Data – Maryland Board of Physicians
- National Data – 2009-2013 National Center for Health Statistics
- National Data – Centers for Medicare and Medicaid Services EHR Incentive Program data, December 2014

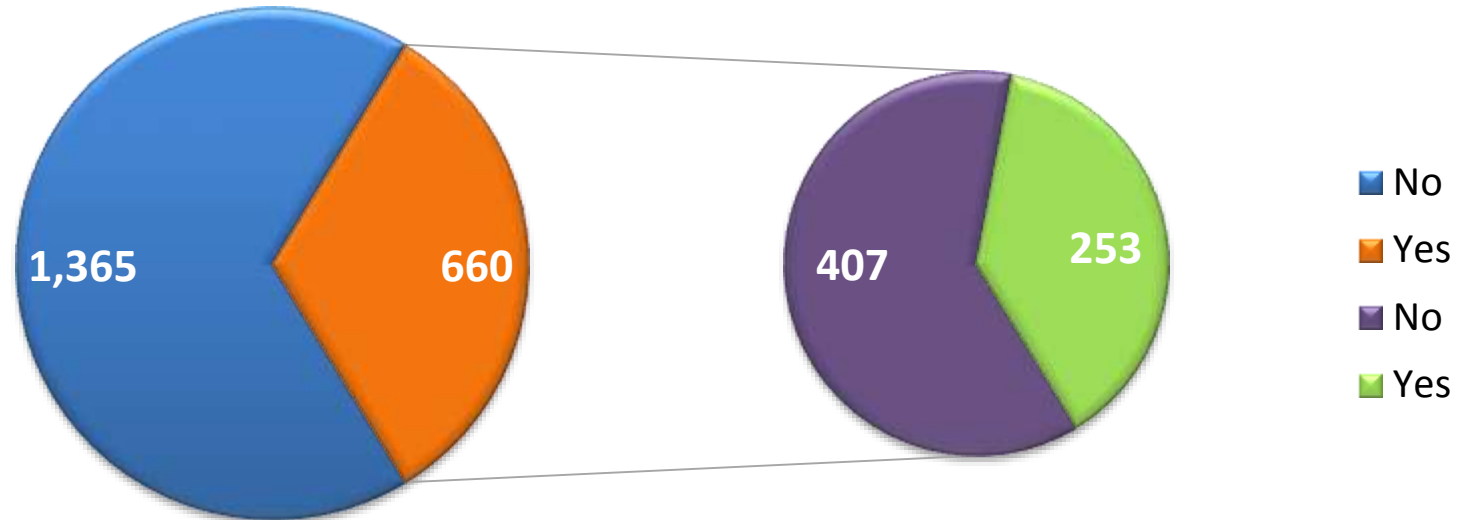
State Incentive Program Progress

- Over \$8.3M to 370 primary care practices since October 2011
- As of March 2015, about 370 primary care practices have received a State Incentive
- Participation has increased by about 14 percent since April 2013
- The average number of applications that resulted in payments increased from 33 per month under the previous program to 43 per month under the revised program

Estimated Federal and State Incentive Program Participation among Primary Care Practices

Received a Federal Incentive?

Received a State Incentive?



About 38 percent of the eligible primary care practices who have received a federal incentive have also received a State incentive; an increase of about 27 percent since April 2013

Sources:

- Data reported by payors for period October 2011 – March 2015
- Medicare and Medicaid EHR Incentive Data, DHMH, March 2015

Next Steps

- **Staff, in collaboration with MedChi, DHMH, CRISP, and the Maryland Nurses Association will continue to target outreach and education efforts to raise awareness about the State incentive program to those :**
 - **407 practices that have received a federal incentive but have not received a State incentive to encourage their participation in the State incentive program**
 - **1,248 practices that have not received either a federal or State incentive**
- **Staff will begin to explore the impact of extending the State incentive program beyond 2016**

Thank You!



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Appendix



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State EHR Incentive Program Progress by Payor

Payor	October 2011 – April 2013		May 2013 - December 2013		January 2014 - September 2014		October 2014 - March 2015		October 2011 - March 2015	
	18 months		8 months		9 months		6 months		40 months	
	Payments Made	Total Amount Paid (\$)	Payments Made	Total Amount Paid (\$)	Payments Made	Total Amount Paid (\$)	Payments Made	Total Amount Paid (\$)	Payments Made	Total Amount Paid (\$)
Aetna, Inc.	84	848,842	47	426,941	106	974,098	52	211,190	289	2,461,071
CareFirst BlueCross BlueShield	86	932,736	84	920,040	98	1,036,976	48	345,425	316	3,235,177
CIGNA Health Care Mid-Atlantic Region	80	31,412	94	63,235	71	52,902	61	77,301	306	224,850
Coventry Health Care	70	551,592	39	326,796	57	452,172	30	29,775	196	1,360,335
Kaiser Permanente	5	39,228	12	47,248	15	108,704	9	32,229	41	227,409
UnitedHealthcare, MidAtlantic Region	85	247,584	75	271,648	46	145,176	57	178,667	263	843,075
Total	410	2,651,394	351	2,055,908	393	2,770,028	257	874,587	1,411	8,351,917
Total Unique Practices	107		124		169		100		370	

Source: Data reported by payors for period October 2011– March 2015

* Includes both Base and Additional incentive amounts, where applicable.

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UPDATE:

Results of the Analysis of Payment for Professional Services

(Agenda Item #7)



Pricing Information from the Medical Care Data Base

Commission Meeting June 18, 2015
Center for Analysis & Information Systems

Overview

- ▶ The MCDB has been a valuable resource for investigating private insurance pricing patterns and trends
- ▶ The Professional Services Report (PSR) was developed in response to a legislative mandate and has provided an annual report of pricing for professional services.
 - ▶ This static report may no longer be needed with the development of dynamic web-based reporting tools
 - ▶ The 2013 PSR results will be presented today
 - ▶ New this year: Medicaid Fee Schedule Changes and Exploration of Network Participation
- ▶ Price transparency initiatives

Pricing Measures in Professional Services Reports

- ▶ **Per user expenditures and service utilization comparisons**
 - ▶ By user, plan, and payer characteristics
 - ▶ Annual change
 - ▶ Presented in the Privately Insured Report
- ▶ **Normalized price (payment per RVU) comparisons**
 - ▶ By payer market share
 - ▶ By provider characteristics
 - ▶ Ratio of average private payment for professional services to payment under Medicare & Medicaid fee schedules

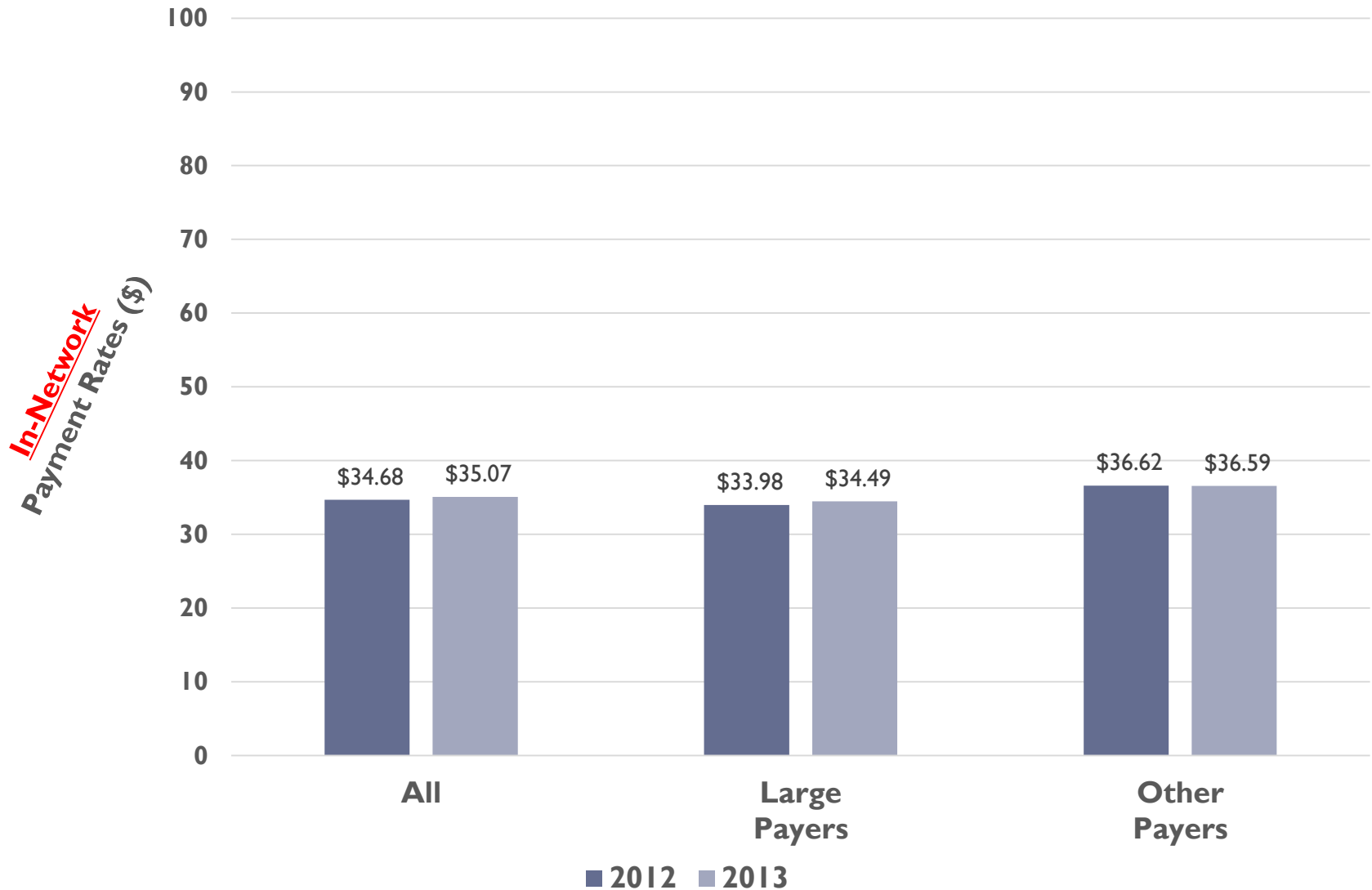
Professional Services Report (2013)

- ▶ Based on MCDB 2013 data for privately insured and based on fee schedule for Medicare and Medicaid
- ▶ Overall private insurance payment rate marginally decreased (2012:\$35.41; 2013:\$35.11)
- ▶ Overall large payers paid about 9% less than other payers in 2013 (Large: \$34.11; Other: \$37.66)
- ▶ In-Network payments marginally increased (2012: \$34.68; 2013: \$35.07)
- ▶ Comparison to Medicare and Medicaid
 - ▶ Overall private rates are on average about 6% lower than Medicare payment rates
 - ▶ *Overall private rates are on average about 8% higher than Medicaid payment rates*

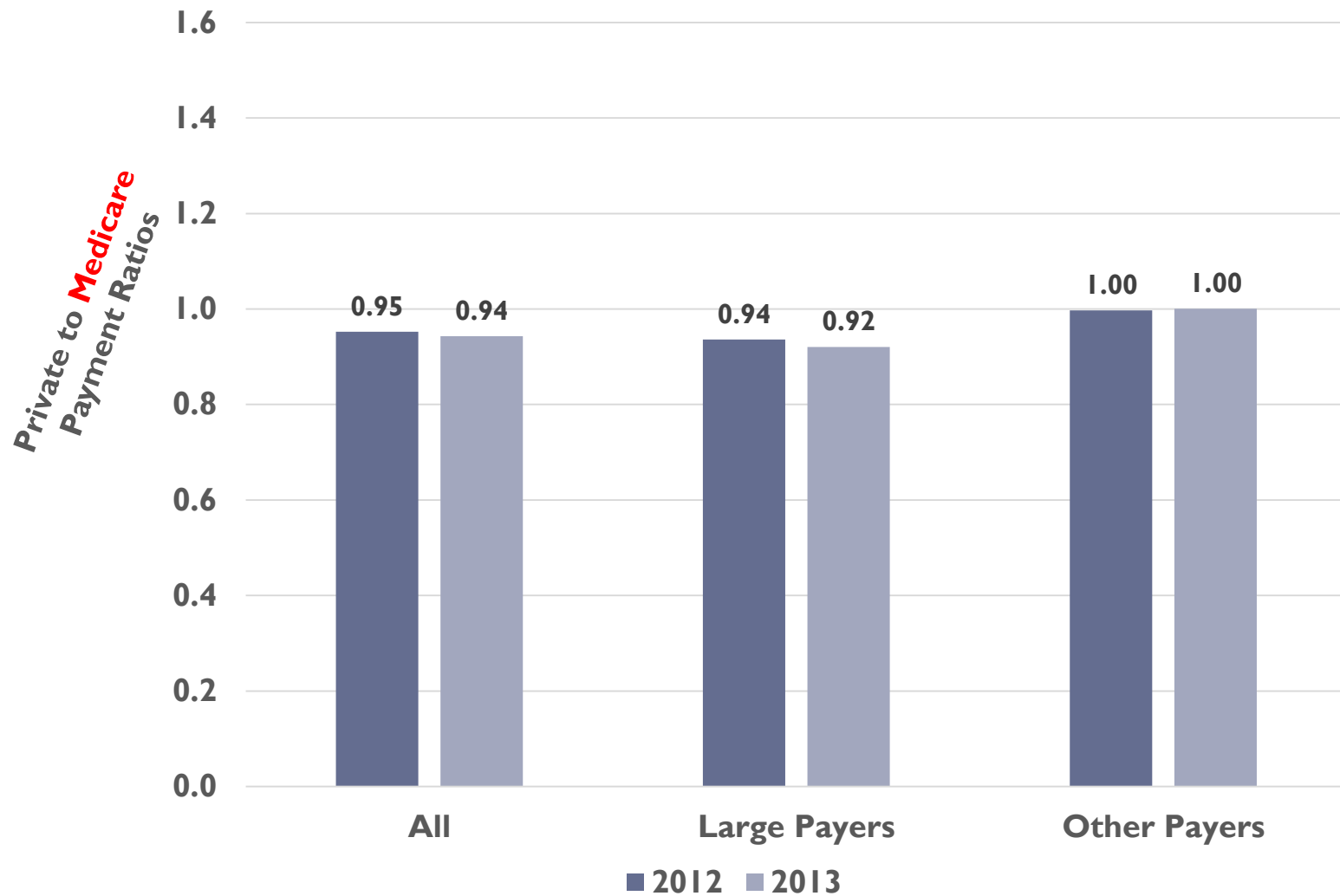
Overall Private Insurance Payment Rates by Payer Market Share, 2012 and 2013



In-Network Private Insurance Payment Rates by Payer Market Share, 2012-2013



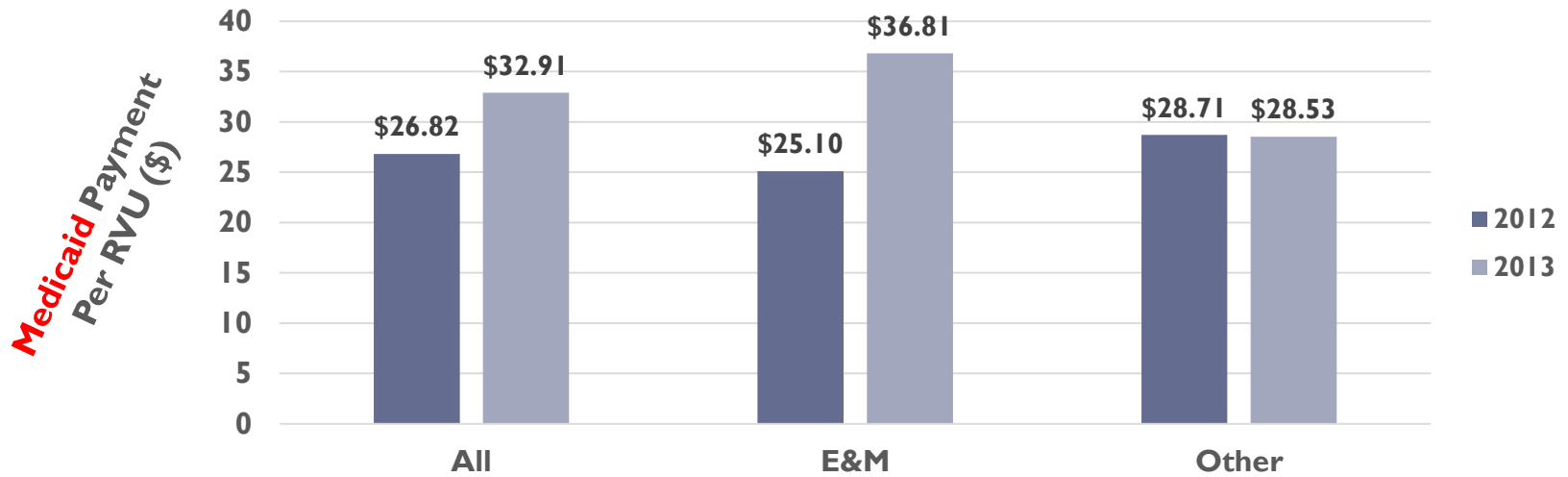
Overall Private Insurance to Medicare Payment Rate Ratios, 2012-2013



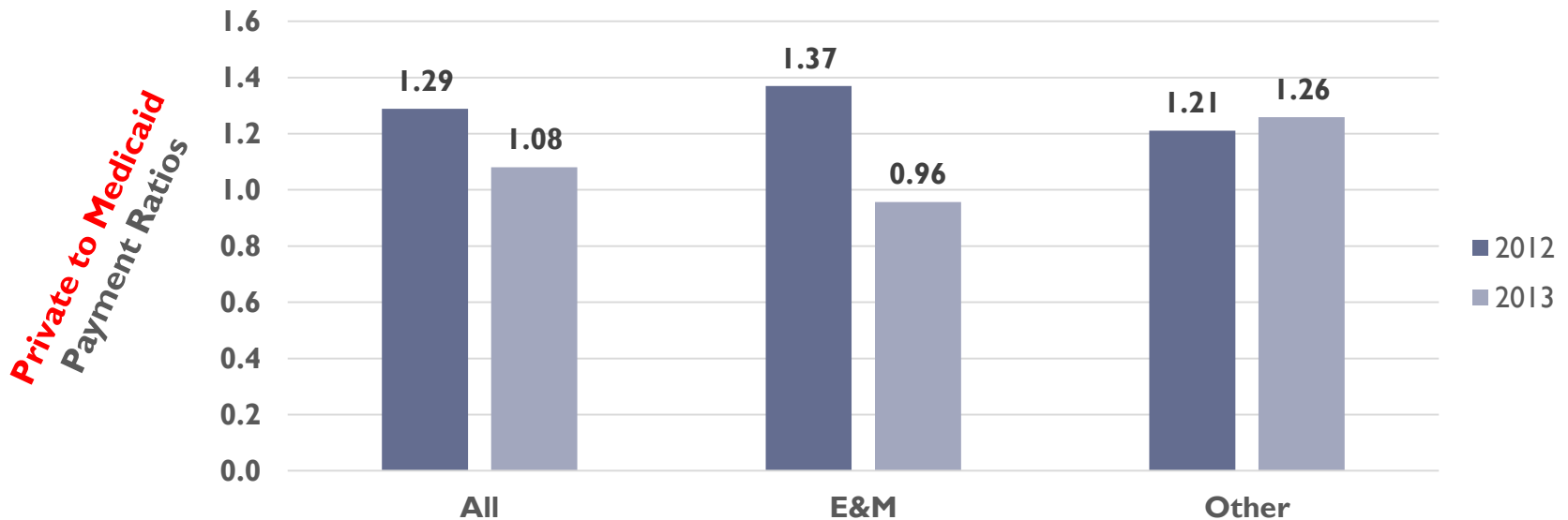
Changes in Medicaid Fee Schedule

- ▶ **Medicaid primary care parity rule in the ACA**
 - ▶ Requires states to pay for primary care Evaluation and Management (E&M) services at the same level as Medicare with the federal government paying the cost increase
 - ▶ Medicaid implemented payment increases in 2013, which resulted in a substantial increase in payment per RVU for E&M
 - ▶ E&M accounts for about half of all RVU's
- ▶ **Medicaid's increased prices narrows the gap overall between Medicaid and both private insurance and Medicare prices**

Medicaid Payment Per RVU by Service Type, 2012-2013



Overall Private Insurance to Medicaid Payment Rate Ratios by Service Type, 2012-2013



Price Transparency Initiatives

- ▶ **Provider Pricing Application**
 - ▶ Provider-level pricing for services
 - ▶ Pairs private insurance and Medicare data
- ▶ **Hospital Elective Surgical Procedures**
 - ▶ Hospital-level pricing for elective surgical procedures
 - ▶ Displays both facility and professional service costs
- ▶ **Consumer and Provider Portals**
 - ▶ Provider-level pricing of services and episodes
 - ▶ Parallel portals targeting consumers and providers

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UPDATE:

Evolution of the Small Group Market

(Agenda Item #8)

Transition of Maryland's Small Group Health Insurance Market

Past, Present, Future

Commission Meeting

June 18, 2015

CSHBP – Benefits and Cost Sharing

- Benefits and cost sharing developed/modified by MHCC with the MIA ensuring carriers provide the benefits required in regulations
- CSHBP includes most of the broad categories of services that are required as essential health benefits under the ACA, including inpatient, outpatient, ER, maternity/newborn care; lab, rehab, habilitative, prevention, wellness services; prescription drug coverage; (mental health parity and pediatric dental care are not the same)
- CSHBP also requires coverage for several legislatively or Commission mandated benefits that apply in the individual & fully-insured large group markets (example: bariatric surgery)
- CSHBP excludes IVF coverage (high cost benefit serving few subscribers)

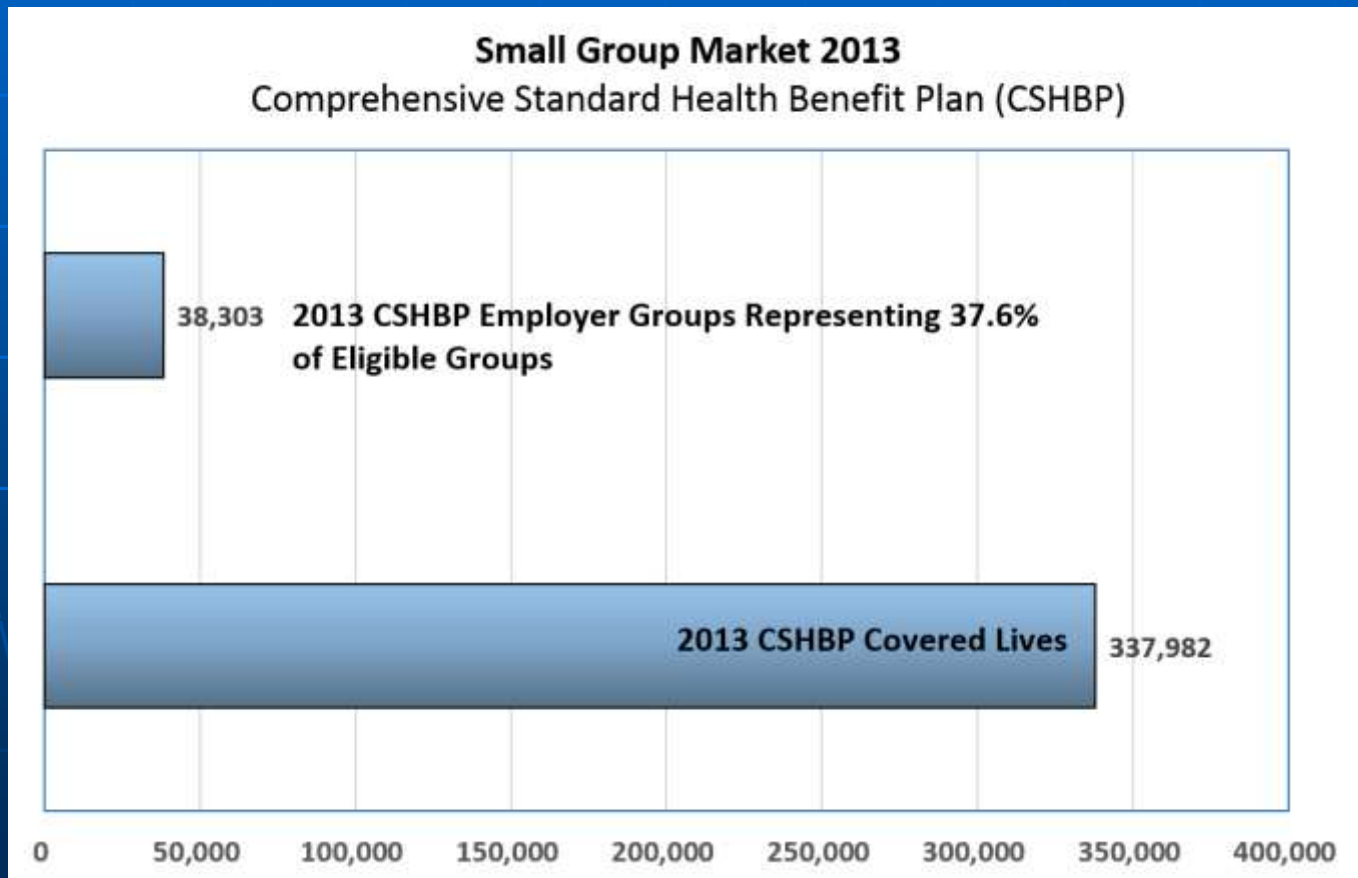


Subsidy Program

- Established in 2007 for small employers not currently offering health insurance to their employees
- At least 2 and no more than 9 eligible employees
- Has not offered a small group policy to its employees in the most recent 12 months
- Average wage of all eligible employees is below \$50,000
- Employer contribution, supplemented by the subsidy, needs to be high enough so that 75% of the full-time employees without group or public health insurance will choose at least employee-only coverage
- The Partnership premium subsidy program **closed to new groups** effective January 1, 2014 with a gradual phase out of enrolled groups upon renewal. No new enrollments as of May 1, 2015

Participation in the CSHBP

(AVERAGE SMALL GROUP IS 8 EMPLOYEES)



SHOP Exchange – 2014/2015

- Development of the Maryland Health Connection for the individual market experienced significant challenges. The launch of SHOP was delayed
- Third Party Administrators (TPA) were authorized to process applications for subsidies via a waiver from CMS as a stop gap measure for 2014
- SHOP uptake was small for 2015
 - Number of SHOP Exchange groups – 85
 - Number of SHOP Exchange enrollees - 549
 - Most of the SGM is purchased **outside** of SHOP
 - One carrier has the bulk of the SGM
- In July, 2014 the Maryland Health Benefit Exchange issued a RFP asking the existing TPAs to submit proposals to operate Maryland's version of a SHOP Exchange. Very limited fixed price funding has been made available for the 3 annual phases of development, but requires the TPAs to have a fully operational web-based SHOP Exchange in the third year
- Proposals were received from the 3 largest TPAs – Kelly & Associates, Group Benefit Services Inc., and Benefit Mall. The MHBE subsequently determined that contracting with all three TPAs was in the best interest of Maryland. The TPAs are the SHOP for 2016 open enrollment in October

Rationale for Using TPAs

- Using the three TPA's was an economically savvy decision by the Exchange as the TPA infrastructure has been in place for years, used by all carriers, highly efficient and significantly less expensive than building a federally certified SHOP
- Using TPAs allows Maryland to meet SHOP requirement without a significant State investment
- The problems in 2014 with the Individual Exchange afforded the MHBE time to scale its approach based on slow SHOP uptake in other states

2013 Average Monthly Premium w/o Riders

Deductible Limits: \$2500/Individual, \$5000/Family; Same Deductible Limits Apply Separately to Pharmacy Benefits

	Employee only
HMO/H.S.A.	\$282.33
HMO	\$360.33
PPO	\$264.92
PPO/H.S.A.	\$383.50

CSHBP plus habilitative services was chosen as the benchmark plan for small group in 2014. CSHBP plus in vitro and habilitative services selected as the benchmark plan in the individual market

SHOP Unique Offerings

- Tax credits are available for small employers up to 2 years. Few employers utilized the tax credit as it was too complicated
- Employee choice models are available only in the SHOP. Employers can pick plans at the same metal level from several carriers. Employees can pick among the plans
 - Small employers have not been enthusiastic and there is little employee demand, perhaps because:
 - per the literature, too many choices making it difficult to understand all the options and make an informed choice
 - brokers do not favor employee choice as it is difficult to explain all the variances to the employees
 - small employers prefer to keep it simple as they do not have HR staff

Tradeoffs Between the CSHBP and SHOP

- In 2014 the SGM moved from composite rating to member-level rating. Historically, employers were offered a premium based on a composite rate for the group based on average age and geographic location. Under ACA, all employees and dependents are age-rated and the cumulative rate is offered to the employee. This rating approach complicates an employer's ability to calculate the employer contribution. Perhaps even more significantly, this change has raised rates for older employees and lowered rates for younger employees
- Under the CSHBP, family premiums were calculated based on the average number of children. Under the ACA, each child in the family up to 3 children is individually rated. All insured children over 18 are individually rated. These rating rules have raised rates for large families and reduced rates for smaller families. The CSHBP composite rate was consistent for all employees

SGM Moving Forward

- Greater use of limited networks to control cost and get higher quality
- SGM products will increasingly have higher out of pocket costs which results in a cohort of the insured avoiding care except in catastrophic situations
- Creative plan designs that will expand the range of pre-deductible services that may prevent future higher cost like lab services and generics
- Some opportunities for plans, due to changes in the market. Evergreen, the COOP plan, has made some headway on SGM

SGM Moving Forward

- Small business (SHOP) health insurance exchanges must open up to businesses with up to 100 employees in 2016
- Employers in this size category must offer products consistent with the Essential Health Benefits package and all other insurance market reforms
- This 2016 expansion could further disrupt the redefined SGM as larger firms with negative illness profiles join the SGM, and firms with younger healthier employees opt to self-insure
- There is greater use of self-insurance in groups near or above 75 employees

EFFORTS TO DISCOURAGE THE USE OF THE STOP LOSS OPTION IN THE SGM

- In 2015 and for renewals, a medical stop-loss policy or contract must have a specific attachment point of not less than \$10,000 or an aggregate attachment point of less than 115% of expected claims
- Legislation this year requires that no new stop-loss policy may not have an attachment point of less than \$22,500 or an aggregate attachment point of less than 120% of expected claims for newly issued policies or contracts. MIA to study the effect of stop loss and report to the legislature in 2016
- A previously issued MHCC report estimated that 15% of the SGM uses the stop-loss option. Even with the expansion to 100 employees, the higher attachment points are expected to stifle growth

Trends and Possibilities for Small Employers

- % of uninsured has declined in Maryland
- Possible future reforms offering broader tax credits with less complexity would generate an uptake resulting in further decline in the uninsured
- Designating the three TPAs as the proxy for SHOP in Maryland is anticipated to stimulate an increase in SHOP employer groups and employees
- Because the ACA is still maturing, rate adjustments are to be expected. Although there were upward rate adjustments prior, for 2016 there are positive indicators with the dominant carrier requesting 17% reductions for four of its plans and 3% reductions for two plans. Most other carrier adjustments are minimal increases of 3-4% with the exception of one carrier requesting a 15% increase for its two plans

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Overview of Upcoming Initiatives

(Agenda Item #9)

The background of the image is the Maryland state flag, which is divided into four quadrants. The top-left and bottom-right quadrants feature a diagonal pattern of alternating black and gold triangles. The top-right and bottom-left quadrants are white with a red cross that has rounded ends. The text "ENJOY THE REST OF YOUR DAY" is centered across the middle of the image in a blue, sans-serif, all-caps font.

ENJOY THE REST OF
YOUR DAY